Standard Form 89
(Rev. Aug. 1950)
BUREAU OF THE BUDGET
CIRCULAR A-32

REPORT OF MEDICAL HISTORY

89-103

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

1. LAST NAME—FIRST NAME—MIDDLE NAME			2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)			5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE: MILITARY / CIVILIAN	10. AGENCY	11. ORGANIZATION UNIT
12. DATE OF BIRTH	13. PLACE OF BIRTH		14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN	
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS			16. OTHER INFORMATION	

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. *(Follow by description of past history, if complaint exists)*

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH
FATHER				
MOTHER				
SPOUSE				
BROTHERS AND SISTERS				
CHILDREN				

19. HAS ANY BLOOD RELATION *(Parent, brother, sister, other)* OR HUSBAND OR WIFE:

YES	NO	(*Check each item*)	RELATION(S)
		HAD TUBERCULOSIS	
		HAD SYPHILIS	
		HAD DIABETES	
		HAD CANCER	
		HAD KIDNEY TROUBLE	
		HAD HEART TROUBLE	
		HAD STOMACH TROUBLE	
		HAD RHEUMATISM *(Arthritis)*	
		HAD ASTHMA, HAY FEVER, HIVES	
		HAD EPILEPSY *(Fits)*	
		COMMITTED SUICIDE	
		BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW *(Place check at left of each item)*

YES	NO	(*Check each item*)	YES	NO	(*Check each item*)	YES	NO	(*Check each item*)	YES	NO	(*Check each item*)
		SCARLET FEVER, ERYSIPELAS			GOITER			TUMOR, GROWTH, CYST, CANCER			"TRICK" OR LOCKED KNEE
		DIPHTHERIA			TUBERCULOSIS			RUPTURE			FOOT TROUBLE
		RHEUMATIC FEVER			SOAKING SWEATS *(Night sweats)*			APPENDICITIS			NEURITIS
		SWOLLEN OR PAINFUL JOINTS			ASTHMA			PILES OR RECTAL DISEASE			PARALYSIS (*Inc. infantile*)
		MUMPS			SHORTNESS OF BREATH			FREQUENT OR PAINFUL URINATION			EPILEPSY OR FITS
		WHOOPING COUGH			PAIN OR PRESSURE IN CHEST			KIDNEY STONE OR BLOOD IN URINE			CAR, TRAIN, SEA, OR AIR SICKNESS
		FREQUENT OR SEVERE HEADACHE			CHRONIC COUGH			SUGAR OR ALBUMIN IN URINE			FREQUENT TROUBLE SLEEPING
		DIZZINESS OR FAINTING SPELLS			PALPITATION OR POUNDING HEART			BOILS			FREQUENT OR TERRIFYING NIGHTMARES
		EYE TROUBLE			HIGH OR LOW BLOOD PRESSURE			VENEREAL DISEASE			DEPRESSION OR EXCESSIVE WORRY
		EAR, NOSE OR THROAT TROUBLE			CRAMPS IN YOUR LEGS			RECENT GAIN OR LOSS OF WEIGHT			LOSS OF MEMORY OR AMNESIA
		RUNNING EARS			FREQUENT INDIGESTION			ARTHRITIS OR RHEUMATISM			BED WETTING
		CHRONIC OR FREQUENT COLDS			STOMACH, LIVER OR INTESTINAL TROUBLE			BONE, JOINT, OR OTHER DEFORMITY			NERVOUS TROUBLE OF ANY SORT
		SEVERE TOOTH OR GUM TROUBLE			GALL BLADDER TROUBLE OR GALL STONES			LAMENESS			ANY DRUG OR NARCOTIC HABIT
		SINUSITIS			JAUNDICE			LOSS OF ARM, LEG, FINGER, OR TOE			EXCESSIVE DRINKING HABIT
		HAY FEVER			ANY REACTION TO SERUM, DRUG OR MEDICINE			PAINFUL OR "TRICK" SHOULDER OR ELBOW			HOMOSEXUAL TENDENCIES

21. HAVE YOU EVER (*Check each item*)				22. FEMALES ONLY: A. HAVE YOU EVER—			B. COMPLETE THE FOLLOWING:
		WORN GLASSES			ATTEMPTED SUICIDE			BEEN PREGNANT		AGE AT ONSET OF MENSTRUATION
		WORN AN ARTIFICIAL EYE			BEEN A SLEEP WALKER			HAD A VAGINAL DISCHARGE		INTERVAL BETWEEN PERIODS
		WORN HEARING AIDS			LIVED WITH ANYONE WHO HAD TUBERCULOSIS			BEEN TREATED FOR A FEMALE DISORDER		DURATION OF PERIODS
		STUTTERED OR STAMMERED			COUGHED UP BLOOD			HAD PAINFUL MENSTRUATION		DATE OF LAST PERIOD
		WORN A BRACE OR BACK SUPPORT			BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION			HAD IRREGULAR MENSTRUATION		QUANTITY: ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS? MONTHS	25. WHAT IS YOUR USUAL OCCUPATION?	26. ARE YOU (*Check one*) ☐ RIGHT HANDED ☐ LEFT HANDED

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
		27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.
		B. INABILITY TO PERFORM CERTAIN MOTIONS
		C. INABILITY TO ASSUME CERTAIN POSITIONS
		D. OTHER MEDICAL REASONS (*If yes, give reasons*)
		28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
		29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (*If yes, give details*)
		30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (*If yes, state reason and give details*)
		31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (*If yes, state reason and give details*)
		32. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? (*If yes, describe and give age at which occurred*)
		33. HAVE YOU EVER BEEN A PATIENT (*committed or voluntary*) IN A MENTAL HOSPITAL OR SANATORIUM? (*If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic*)
		34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (*If yes, specify when, where, and give details*)
		35. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? (*If yes, give complete address of doctor, hospital, clinic, and details*)
		36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (*If yes, which illnesses*)
		37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date and reason for rejection*)
		38. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability*)
		39. HAVE YOU EVER RECEIVED, IS THERE PENDING, HAVE YOU APPLIED FOR, OR DO YOU INTEND TO APPLY FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? (*If yes, specify what kind, granted by whom, and what amount, when, why*)

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.
I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

40. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (*Physician shall comment on all positive answers in items 20 thru 39*)

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

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